STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	07/13/2017

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from July 5, 2017 through July 13, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 124. The survey sample totaled forty-five (45). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LCSW - Licensed Clinical Social Worker LPN - Licensed Practical Nurse; NP - Nurse Practitioner UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; NP - Nurse Practitioner; PA - Physician Assistant; FMD-Facility Maintenance Director; SW - Social Worker; Abilify - an antipsychotic medication, ADLs - Activities of Daily Living, such as bathing and dressing; Amputation-surgical removal of all or part of a limb or extremity; Anxiety - intense, excessive and persistent worry or fear about everyday situations;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal, Seroquel);
Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness;
Anxiety - feeling worry, nervous or restless;
ARD - Assessment Reference Date;
Arterial pressure-pressure in the vessels leaving the heart;
AEB - as evidence by
AIMS (Abnormal Involuntary Movement Scale) - test to measure body movements the resident cannot control, side effects of antipsychotic medications;
Ativan - a medication used to treat anxiety disorders;
Bactericidal - a substance that kills bacteria;
BID - two times daily
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15.
13-15 Cognitively Intact
8-12 Moderately Impaired
0-7 Severe Impairment
BP - Blood Pressure;
Care Area Summary (CAA) - part of the MDS assessment to identify and plan for problem areas;
CDC - Centers for Disease Control and Prevention;
Cerebral infarction - Stroke
CHF (Congestive Heart Failure) - heart cannot pump enough blood to meet the body's needs causing fluid build up in lungs/legs;
Cognitive function - mental abilities;
Cognitively intact - able to make own decisions;
Communicable Disease - disease that is spread from one person to another;
Continence - control of bladder and bowel

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F 000	Continued From page 2	F 000		

function;
Delirious / Delirium -brief state of excitement and mental confusion;
Delusion -false belief that is thought to be true;
Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
Depakote - seizure medication also used mood stabilizer
Depression -mood disorder with feelings of sadness;
e.g. - an abbreviation that means "for example;"
ie - an abbreviation used to give more information about something that was just mentioned;
etc. - an abbreviation for the Latin word et criteria - which means "and so on;"
EMR - Electronic Medical Record;
ER - Emergency room;
F (Fahrenheit) - measurement of temperature;
Germicidal - a substance that kills germs/bacteria;
Glucometer - medical device that reads blood sugar levels;
Hallucinations - something that seems real but does not really exist;
MAR - Medication Administration Record;
MDS (Minimum Data Set) - standardized assessment used in nursing homes;
Medication Regimen Review (MRR) - monthly review resident's medications, laboratory tests etc. by a pharmacist to see if anything unusual exist;
mL (milliliters) - measurement of liquid 5 ml = 1 teaspoon
mg (milligrams) - measurement of weight;
Nitroglycerin - medication that dissolves under the tongue to increase blood supply to the heart;
Nutritional supplement - high calorie liquid drink;
Pain Scale - rating pain severity on a 0 to 10

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F 000	Continued From page 3 scale with 0 meaning no pain and 10 meaning the worst pain; PAS Unit - Preadmission Screening Unit - Screening tool for identification of persons with possible mental illness or mental retardation or related conditions who are applying to or residing in medicare and or medicaid certified nursing facilities; POS (Physician Order Sheet) - monthly list of current physician orders; Pre - before; Post - after; PASARR - Pre-Admission Screening and Annual Resident Review - an evaluation performed for determination of mental illness and recommendations; lbs (pounds) - an abbreviation for weight; % - percentage; PPD - a skin test used as a tool to screen for TB; PRN-when necessary; Pressure ulcer - sore area of skin that develops when blood supply to it is cut off due to pressure of laying/sitting on it; Psychosis - loss of contact/touch with reality; Psychotic - loss of contact ability to think rationally; Psychotropic - medication capable of affecting the mind, emotion, and behavior; Q - every; qd - every day (daily); HS - hour of sleep; RAI - Resident Assessment Instrument; Schizophrenia - mental disorder with false beliefs, confused thinking and bizarre thoughts; Seroquel - antipsychotic medication; Tab Alarm - clip attached to the resident that alerts staff when resident attempts to rise out of a chair/bed without assistance; TID - three times a day;	F 000		

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F 000	Continued From page 4 TB - tuberculosis (lung infection caused by a bacteria); Vascular Dementia - dementia caused by problems with blood flow to the brain;	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to promote care in a way that ensures dignity and respect for two (R139, R262) out of 45 sampled residents. Findings include: 1. On 7/5/17 at 3:33 PM E11 (CNA) knocked then entered R139's without receiving permission to enter from the resident. On 7/12/17 at 8:57 AM E10 (CNA) knocked then entered R139's room without permission to enter from the resident. During an interview on 7/12/17 at 8:59 AM with R139 when asked whether staff knock and ask permission before entering the room, R139 stated "some do and some don't." R139 then stated "it bothers me I can't say it doesn't because it startles me sometimes if I'm sleep and because I'm blind" 2. On 7/7/17 at 11:06 AM E12 (CNA) knocked then entered R262's room without permission to	F 241	A. R262 no longer resides in facility. Staff caring for R139 were instructed to wait for permission to enter after knocking on resident's door. B. Current residents have the potential to be affected. C. The Nurse Practice Educator (NPE) is re-educating all staff on the process for entering residents' rooms. D. The Center Executive Director (CED)/designee will complete audits (Attachment 1) on 10% of the resident population daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. The audit results will be presented to the monthly Quality Assurance Performance Improvement	8/26/17

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F 241	Continued From page 5 enter from the resident. These findings were reviewed on 7/13/17 at 2:15 PM during exit conference with E1 (NHA) and E2 (DON).	F 241	(QAPI) Committee meetings for review & recommendations.	
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on surveyor observations and a resident interview, it was determined that the facility failed to ensure resident rooms were in good repair and that a privacy curtain was clean. This deficient practice was evident for 4 of 33 rooms observed during Stage 1 and Stage II. Findings include: Surveyor observations and interview revealed: On 7/5/17 at 2:08 PM Room 220 - privacy curtain stained and there was wheelchair damage in bathroom and walls 7/5/17 at 3:55 PM Room 112 - wheelchair damage to walls in bedroom 7/7/17 at 11:21 AM Room 221- walls are scarred, in room and bathroom 7/7/17 at 1:04 PM Room 118 - areas of room, bathroom door jam, and the bathroom door were damaged	F 253	A. Maintenance has repaired the wall damage in rooms 112, 118, 220 and 221. The privacy curtain in room 220 has been cleaned. B. Current residents have the potential to be affected. Resident rooms were reviewed and any repairs or replacement of privacy curtains has been completed. C. The CED/designee will complete education with staff on the needed evaluation and documentation of rooms for maintenance and housekeeping needs. D. CED/designee will complete room inspection audits (Attachment 1) on 10% of the resident rooms daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be	8/26/17

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F 253	Continued From page 6 7/13/17 between 9:35 AM and 9:43 AM, a surveyor observed that the above findings were still present. The surveyor interviewed a resident who chooses to be anonymous that stated he/she is not aware of staff ever taking a privacy curtain down to clean. The surveyor discussed the above findings with E1 (NHA) and E2 (DON) at the exit conference on 7/13/17 at approximately 2:15 PM.	F 253	presented to the monthly QAPI committee for review & recommendations.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 272		8/26/17

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F 272	Continued From page 7 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the comprehensive assessment included all active diagnoses for two (R37 and R241) out of 45 sampled residents. Findings include: 1. Review of R37's closed clinical record revealed: 6/5/17 - Admission to facility with multiple diagnoses including anemia. 6/6/17 - R37's care plan included a problem for anemia. 6/8/17 - Physicians' orders included iron tablet [medication used to treat] twice daily for anemia.	F 272	A. A corrected MDS was completed and transmitted for R37 & R241 with acceptance on 8/2/17. B. Current residents have the potential to be affected. C. Center Nurse Executive (CNE) educated Clinical Reimbursement Coordinator (CRC) on accuracy of MDS coding for active diagnosis on 8/1/17. D. The CNE/designee will audit (Attachment 2)Section I of Admission MDSs for accuracy on 10% of the resident population weekly until 100% compliance is achieved on 4 consecutive weeks, then	

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F 272	Continued From page 8 6/12/17 Admission MDS Assessment - List of active diagnoses did not include anemia. During an interview with E8 (RNAC) on 7/12/17 at 2:36 PM E8 confirmed that the diagnosis of anemia was on the admission History and Physical (H & P) but was entered as a history instead of an active diagnosis since the treatment (iron) was not identified. 2. Review of R241's closed record revealed: 3/29/17 - Admission to facility for rehabilitation after hospitalization for respiratory issues complicated by blood clot(s) in the lungs (Pulmonary Embolism - PE). Admission physicians' orders included a blood thinner twice a day for the PE. 3/30/17 - R241's care plan included the problem for risk for bleeding due to being on the blood thinner. 4/5/17 - Admission MDS Assessment - List of active diagnoses did not include the blood clot(s). During an interview with E8 [RNAC] on 7/12/17 at 2:34 PM the RNAC confirmed the PE diagnosis was on the H&P and should have been included on the MDS assessment. These findings were reviewed with E1 (NHA) and E2 (DON) on 7/13/17 at 2:15 PM.	F 272	monthly until 100% compliance is achieved on 5 consecutive months. Results of audits will be reported in the monthly QAPI committee meeting for review and recommendations.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must	F 276		8/26/17

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F 276	Continued From page 9 assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the quarterly MDS assessment was completed within the required time frame for one (R50) out of 45 sampled residents. Findings include: Review of R50's clinical record revealed: 6/19/17 Quarterly MDS Assessment - Status listed as "in progress" with 11 out of 16 sections incomplete. The 2014 instruction manual (RAI Version 3.0 Manual) for the MDS assessment, section 2.3 entitled Responsibilities of Nursing Homes for Completing Assessments, specified the required time frames for completion and submission of MDS assessments: - Assessment and CAA completion no later than 14 calendar days from the ARD. - Care Plan developed no later than 7 calendar days from the CAA completion date. - Electronic submission to CMS (Centers for Medicare &Medicaid Services) no later than 14 calendar days from MDS completion date. Based on the ARD date of 6/19/17, R50's quarterly MDS assessment should have been completed by 7/3/17 and the care plan developed by 7/10/17. During an interview with E8 (RNAC) on 7/12/17 at 2:47 PM E8 stated that it was "late" and was "on	F 276	A. R50 Quarterly MDS was completed, transmitted and accepted on 7/12/17. B. Current residents were reviewed and Quarterly MDS Assessments are in place per OBRA requirements. C. The CRC/Interdisciplinary Team completing MDSs were in-serviced on the OBRA Assessment Completion on 8/1/17. D. The CNE/Designee will audit (Attachment 2) MDS completion dates on 100% of the MDSs in the EMR weekly until 100% compliance is achieved on 4 consecutive reviews, then 10% of the resident population monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be reported in the monthly QAPI committee meeting for review and recommendations.	

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F 276	Continued From page 10 the list to be done." These findings were reviewed with E1 (NHA) and E2 (DON) on 7/13/17 at 2:15 PM.	F 276		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		8/26/17

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F 280	Continued From page 11 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 280		

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F 280	Continued From page 12 or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to update the care plan for 1 (R50) out of 45 sampled residents by including a fall prevention strategy added after the resident fell. Findings include: Review of R50's clinical record revealed: 3/17/17 - Care plan problem for risk for falls included the following interventions: Physical Therapy treatment as ordered; Provide verbal cues for safety and sequencing when needed; Place call light within reach while in bed or close proximity to the bed; Remind resident to use call light when attempting to ambulate or transfer; Maintain a clutter-free environment in the resident's room and consistent furniture arrangement; When in bed place all necessary personal items within reach; Monitor for and assist toileting needs. 6/13/17 - Progress note documented R50 fell without injury when transferring self back to bed. 6/13/17 - Physicians' order included to use a tag (body) alarm and check placement/function every shift. The care plan was not updated to include the additional fall prevention intervention.	F 280	A. R50 care plan was reviewed and updated for fall prevention strategies on 8/1/17. B. All residents with fall prevention alarms were identified and care plans are currently in place for the alarms. C. Nurses will receive re-education for updating care plans when a new intervention for fall prevention is initiated. D. The Nurse Unit Managers will complete post-fall care plan audits (Attachment 3) on 100% of residents having a fall daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be reported to the monthly QAPI committee meeting for review and recommendations.	

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F 280	Continued From page 13 During an interview with E2 (DON) on 7/12/17 around 4:10 PM, when discussing the resident the surveyor mentioned that the tag alarm had not been included in R50's care plan. This finding was reviewed with E1 (NHA) and E2 on 7/13/17 at 2:15 PM.	F 280		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 285		8/26/17

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F 285	Continued From page 14 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the	F 285		

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F 285	Continued From page 15 preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of external facility documentation it was determined	F 285	A. R129 has a current Level 2 PASRR on file.	

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F 285	Continued From page 16 that for one (R129) out 45 sampled residents the facility failed to ensure the completion of Preadmission screening. Findings include: The following was reviewed in R129's clinical record: 11/13/16 - State of Delaware uses a screening tool [PASARR] for persons with possible mental illness, mental retardation or related conditions who are applying to or residing in Medicare and/or Medicaid certified nursing facilities. The form identified that R129 had a diagnosis of schizophrenia and was on medication for mental illness. The form was completed and signed by E14 (a social worker from the managed care insurance company) but the determination of need for PASARR assessment section was not completed. 11/13/16 - Resident was admitted to the facility from the community. 7/11/17 around 2:40 PM - Interview with E13 (Social Worker) and a follow-up written statement revealed that there was a mix-up with the Level 1 PASARR not being handled properly and the resident should not have been admitted (with an incomplete assessment). The resident was receiving mental health counseling visits since admission. E13's statement documented that in December 2016 an application for long term Medicaid was completed. On 12/22/16 the PAS [Pre Admission Screening] unit made a determination that R129 did not have a level of care for nursing home placement and that a Level 2 PASARR should have been completed for this resident. 7/12/17 2:43 PM - Interview with E15 (State PAS nurse) confirmed that the Level 1 PASARR was not completed prior to admission to the facility. It was further revealed that had Level 1 screening	F 285	B. Current residents have appropriate PASRR screening in place. C. Admissions, Social Services and Nurse Management staff received re-education regarding PASRR requirements from the Delaware PASRR Unit on December 22, 2016. The Center is obtaining completed PASRR screens on all admissions prior to transportation being set up for admission to the Center. D. The Social Service Director/designee will complete audits (Attachment 4) for all admissions daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be presented to the monthly QAPI committee meetings for review & recommendations.	

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F 285	Continued From page 17 been forwarded to the PAS unit for review a Level 2 screening would have been required prior to admission to the facility. When R129's Level 2 PASARR was completed in May 2017 it indicated the resident needed specialized services for mental illness while residing in the facility. These findings were reviewed with E1 (NHA) and E2 (DON) on 7/14/17 at 2:15 PM.	F 285		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309		8/26/17

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F 309	Continued From page 18 and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to assess the resident before and/or after PRN medication administration for pain for one (R50) out of 45 sampled residents. Findings include: Facility policy entitled Medication Administration (last revised 5/15/17) included the practice standard of documenting medication administration on the MAR, including the effectiveness of PRN medication. 2002 - Pain management standards from the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Review of R50's clinical record revealed: 3/17/17 - Admission to facility with multiple diagnoses including chronic pain. Admission physicians' orders included two extra strength	F 309	A. R50 remains in facility and staff are documenting before and/or after PRN medication administration for assessment of pain. B. Current residents have the potential to be affected. C. The NPE will complete re-education with licensed staff on pre and post pain medication assessments and documentation using policy NSG227 Pain Management (Attachment 5). D. The Nurse Unit Manager/Designee will complete daily audits (Attachment 6) on 10% of the resident population until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be reported to the monthly QAPI committee meeting for review and recommendations.	

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F 309	Continued From page 19 Tylenol to be given every 8 hours PRN for pain. 3/17/17 - Care plan problem for alteration in comfort related to chronic pain included the following interventions: Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors; Utilize pain scale; Advise resident to request pain medication before pain becomes severe; Medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated. March 2017 - June 2017 MARs showed the resident received 8 doses of the PRN medication for pain and was missing the following pain assessments for 6 of the 8 administrations: - Pre and post assessment: March 27 (3:40 PM); April 18 (5:00 PM), April 21 (5:15 PM), April 23 (3:45 PM) and April 24 (12:30 PM). - Post assessment: 6/26/17 (5:48 AM). March 2017 - June 2017: Review of Progress Notes found no additional assessments regarding the need for, or effectiveness of, the PRN pain medication administrations. During an interview with E2 (DON) on 7/12/17 at 4:10 PM the surveyor reviewed the missing assessments. The next morning 7/13/17 around 8:30 AM, E2 confirmed the lack of assessments for the 6 PRN pain medication administrations. This finding was reviewed with E1 (NHA) and E2 on 7/13/17 at 2:15 PM.	F 309		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		8/26/17

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F 325	Continued From page 20 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R163 and R37) out of 45 sampled residents the facility failed to ensure measures were implemented to maintain optimal nutritional status/weight. For R163 a potential weight loss was not reassessed. For R37 ordered daily weights were not done. Findings include: Facility Policy for Weights and Heights last revised 11/30/15 documented: If a patient's weight is less than or greater than five pounds from the previous weight, the patient will be re-weighed and the weight verified by a licensed nurse to determine accuracy. 1. The following was reviewed in R163's clinical record: 4/6/17 - Admission to facility with weight of 126	F 325	A. R163 & R37 were both discharged from facility not related to deficient practice. B. Current residents have the potential to be affected. C. A new process has been developed for the Unit Manager/designee to run the Weight Exception Report in the EMR daily with follow up for re-weights on residents with significant weight change. The NPE will complete re-education with licensed staff on NSG244 Weights and Heights (Attachment 7). The Nurse Unit Manager will review all admission orders for appropriate order and transcription per policy.	

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F 325	Continued From page 21 lbs in the EMR. 4/10/17 - EMR documented weight of 125.4 lbs. 4/11/17 - Admission Nutritional Assessment indicated a usual body weight of 125 lbs and a most recent weight of 126 lbs as well as a 1500 ml fluid restriction. 4/11/17 - Care plan for resident is a nutritional risk: self reported food interferences, oral fluid restriction with a goal that resident will maintain stabilized weight of 126 pounds without 7.5% change during the next 90 days. Interventions included to weigh and alert dietitian and physician to any significant loss or gain. 4/17/17 - EMR documented weight of 110.6 lbs (15.4 pounds or 12% loss) 4/18/17 10:23 AM - RD note that 4/17/17 weight reflects a significant loss from admission of 15.4% (actually pounds). A re-weight is requested as difference is > [greater] 5# [pounds]. 4/21/17 - R163 discharged from facility to home. 4/25/17 - EMR Weight Warning note for 110.6 lbs on 4/17/17 with note "re-weight requested, resident discharged before obtained. No weights could be found in the medical record after 4/17/17. 7/12/17 11:35 AM - Interview with E6 (RD) revealed that the weight of 110.6 lbs created an alert in the EMR system and s/he requested a re-weight on 4/18/17. On 4/25/17 she noticed the alert was still active in the EMR and cleared it out	F 325	D. The Nurse Unit Manager/designee will completed audits (Attachment 8) for weights on all admissions daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be reported to the monthly QAPI committee meeting for review and recommendations.	

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F 325	Continued From page 22 by writing the above note for the Weight Warning alert indicating the resident was discharged before the re-weight was obtained. The facility failed to reassess R163's weight. 2. Review of R37's closed medical record revealed: 6/5/17 - Admission to facility with multiple diagnoses including kidney (renal) failure and CHF - both conditions can cause fluctuations in weight due to fluid accumulation. 6/8/17 - Physicians' orders included daily weights. 6/8/17 - R37's care plan included several entries regarding nutrition: - Risk for Fluid Volume Excess as evidenced by renal failure included the intervention to monitor weight daily. - Resident is at Nutritional risk due to obesity, therapeutic diet, average meal completion around 50% with complaint of decreased appetite. Interventions included to weigh daily. 6/8/17 - Nutrition Assessment documented R37 was independent with feeding and reported not much appetite and was not eating usual amounts. Nutritional goal for weight maintenance/prevention of significant change/gradual weight loss during short stay rehab. Meal completion variable, average 54% since admission, not really accepting snacks. Current meal completion does not yet appear adequate to meet calculated maintenance requirements. Coordination of nutrition care included weight monitoring.	F 325		

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F 325	Continued From page 23 June 2017 - July 2017 Weights - Review discovered weights were completed on June 6, 7, 14, 21, 28 and July 5. Weights were done weekly, not daily. 6/29/17 - Nutrition Note about weight meeting with UM found no evidence that the facility was aware that R37 had not been weighed daily since the 6/8/17 order. During an interview with E2 (DON) on 07/11/17 at 1:57 PM E2 confirmed daily weights were not completed for R37. During an interview with E6 (RD) on 7/12/17 at 3:10 PM when discussing monitoring resident weights, E6 stated that weight meetings are conducted weekly to keep an eye on those who have triggered for, or are close to, a weight change and that the UM keeps a log of who is discussed. The dietitian stated s/he was not aware that R37 had not been weighed daily even though the resident was reviewed on 6/29/17 at a weight meeting. These findings were reviewed with E1 (NHA) and E2 on 7/13/17 at 2:15 PM.	F 325		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or	F 329		8/26/17

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F 329	Continued From page 24 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R191 and R50) out of 45 sampled residents the facility failed to ensure adequate indication for use and monitoring of medications. R191 was on anti-psychotic medication in the absence of symptoms that warranted its use and without monitoring of behaviors and side effects. R50 was administered	F 329	A. AIMs was completed for R191 on 7/12/17. Current monitoring for any observed behaviors was initiated for R191. R50 has not required use of nitroglycerin since 6/26/17. B. Current residents have the potential to be affected. Residents on Psychotropic	

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F 329	Continued From page 25 a heart medications in the absence of symptoms and monitoring. Findings include: 1. The following was reviewed in R191's record: R191 had diagnoses which included cerebral infarction, altered mental status, vascular dementia with behavioral disturbances, major depressive disorder, anxiety disorder, psychotic disorder not due to substance abuse or known physiological condition. 10/4/16 - Care plan for resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to sadness/depression, anxiety, fear, sexual aggression with approaches that included: -monitor for signs of delirium, including delusions/hallucinations, notify physician. 10/4/16 - Care plan for resident is at risk for complications related to the use of psychotropic drugs with approaches that included complete behavior monitoring flow sheet. 1/6/17 - Seroquel 25 mg bid for psychotic behaviors. No AIMS assessment was found upon initiation of this anti-psychotic medication. 2/14/17 - Ativan 0.5 mg qhs for anxiety and restlessness. Also on Ativan 25 mg q 6 prn for anxiety, belligerence and refusal to take meds. 3/29/17 - Quarterly MDS indicated severe cognitive impairment, no hallucinations, delusions, behaviors or rejection of care during the assessment period and the use of anti-psychotic, anti-anxiety and antidepressant medications daily.	F 329	medications are reviewed weekly during behavior rounds to ensure the medications are appropriate. The records for residents on nitroglycerin have been reviewed to ensure proper pre and post assessment was conducted. C. The NPE will complete re-education with licensed nursing staff for behavior monitoring, nitroglycerin administration and NSG227 Pain Management (Attachment 5) Education includes assessment and documentation for psychotropic, vasodilator and pain medication. D. The CNE/designee will complete daily audits (Attachment 6) for 10% of the resident population for AIMs completion & appropriate documentation for assessment of pain post medication administration until 100% compliance achieved on 3 consecutive reviews, then weekly until 100% compliance achieved on 3 consecutive reviews, then monthly until 100% achieved on 3 consecutive reviews. Results of audits will be reported to the monthly QAPI committee meeting for review and recommendations.	

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F 329	Continued From page 26 4/17/17 - Psychiatric NP note ...no hallucinations or delusions noted....nursing staff reports patient's behavior has been stable. Sometimes gets agitated with care, re-directable...monitor behaviors. 5/8/17 - LCSW note ...he denied current symptoms of anxiety and depression...staff report no changes. 5/15/17 - Psychiatric NP ...chief complaint agitation; patient seen in his room, alert to self, mood was calm and pleasant, denies depressed mood, states he is doing ok, no hallucination or delusions noted, reports good appetite and sleeps ok, nursing staff reports patients behavior has been stable. Sometimes gets agitated with care, and curses staff, redirectable....plan to decrease Depakote to 250 mg bid from tid, will continue to monitor behaviors. 5/17/17 - Physician's order for Depakote sprinkles 250 mg bid for behavioral disturbances. 6/19/18 - LCSW note ...patient presented in a pleasant mood. He was seen laying in bed during visit. He denied current symptoms of anxiety and depression. Patient reports no new concerns or issues. 6/28/17 - Psychiatric NP note ...patient is agitated, combative, verbally and physically aggressive towards staff. Target behaviors-behavioral disturbances, changes in mood...add abilify 5 mg to current regimen to decrease behaviors. 6/28/17 - Abilify 5 mg qd for psychosis. No AIMS	F 329		

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F 329	Continued From page 27 assessment was initiated for use of this anti-psychotic medication. April 2017 - July 2017 Behavior Monitoring sheets completed by nursing revealed the monitoring of hitting, withdrawn, nervous, jittery, restless, scratching and grabbing. There were no documented behaviors during these 3 1/2 months. April 2017 - July 2017 Review of nursing progress notes documented the following behaviors: 4/2/17 2:51 AM - Resident has been very physically and verbally aggressive to staff. Spitting, kicking and cursing at CNA's while doing care. Resident refused medications times 3. 4/2/17 9:00 PM - Late entry note Resident continues to be physically aggressive with CNA doing his care. He hit CNA in her breast pretty hard. 4/27/17 2:00 PM - Care plan evaluation summarizing CNA documentation of cursing 10 times, physical aggression 9 times and sexually inappropriate behavior 1 time. 5/30/17 6:14 AM - Resident refused to get in to bed until approximately 3:30 (AM); 2:14 PM refusing medications. 6/1/17 1:29 AM - Resident refusing medications. 6/12/17 11:38 AM - Refused suppository but accepted oral medication for constipation. 6/14/17 2:22 PM - Resident noted to be uncooperative this shift. Resident punched CNA in her eye. Resident also refused meals and medications this shift. 6/25/17 3:23 PM - Resident refusing all medications plus lunch. Refuses to let CNA's change him. April 2017 - July 2017 CNA Documentation	F 329		

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F 329	Continued From page 28 Report completed by the direct care staff documented the following behaviors and number of episodes: - physical aggression aeb [as evidenced by] hits and kicks staff: April - 7, May - 4, June - 10, July - 2. - socially inappropriate aeb sexual comments: April - 2, May - 7, June - 8, July - 3. - verbal aggression aeb curses and swears at staff: April - 8, May - 3, June - 13, July- 2. There was no monitoring sheets for hallucinations or delusions as indicated in the care plan. There was no evidence from the clinical record including progress notes and monitoring forms that R191 was displaying signs and symptoms of psychosis, psychotic behavior, delusions or hallucinations. 7/12/17 11:03 AM - Interview with E18 (LPN) about the behaviors that anti-psychotic medication were being used for revealed that R191 gets combative with staff, yells out and starts cursing at staff, refuses medications at times. E18 added that the resident has some agitation / anxiety, increased behaviors in the evenings, gets combative with staff, refuses to eat and refuses care. E18 stated that non medication interventions do not work well and staff will leave and reapproach later. No AIMS Assesement could be found in the medical record by E18. There was no mention of delusions or hallucinations as a behavior / symptom. 2. Facility policy entitled Medication Administration (last revised 5/15/17) included the practice standard of documenting medication administration on the MAR, including the effectiveness of PRN medication.	F 329		

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F 329	Continued From page 29 Review of R50's clinical record revealed: 3/17/17 - Admission to facility with multiple diagnoses including heart disease. Admission physicians' order included nitroglycerin to be given every 5 minutes for 3 doses PRN for chest pain. March 2017 - June 2017 - Review of MARs discovered R50 received nitroglycerin on June 26 (5:15 AM). - Review of progress notes and assessments found no evidence of assessment indicating the need for, or the effectiveness of, the PRN medication. During an interview with E2 (DON) on 7/13/17 at 8:30 AM, E2 confirmed there was no indication for use including assessments surrounding the PRN medication administration of nitroglycerin. These findings were reviewed with E1 (NHA) and E2 on 7/13/17 at 2:15 PM.	F 329		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 353		7/26/17

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F 353	Continued From page 30 at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents it was determined that the facility failed to have sufficient nursing staff to provide nursing and/or ensure that staffing levels for	F 353	A. The facility has met with and followed up with residents' documented grievances. The Facility continues to conduct Resident Council meetings	

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F 353	Continued From page 31 nursing were adequate to meet the needs of residents. Ten Residents [A1, A2, A3, A4, A5, A6, A7, A8, A9, A10] out of 10 reviewed, who wish to remain anonymous, expressed concerns during stage 1 of the survey, in resident council and expressed concerns through grievance/concern forms. Findings include: 6/5/17 Resident council meeting minutes documented "CNA's get an attitude when you have to be put on the bed pan and has waited over an hour for help. CNA's should have coverage on the floor for breaks and lunch." 6/20/17 A resident grievance form was completed for the following concern " CNA's should have coverage on the floor for breaks and lunch." 6/21/17 A resident grievance form documented the following "the CNA's we have are good but we don't have enough of them." 6/21/17 A resident grievance form documented the following "CNA's get an attitude when you have to be put on the bedpan and has waited over a hour for help." During an interview on 7/11/17 at 1:07 PM with R228 who is the resident council president it was reported that the "biggest problem is clothing from the laundry and staffing. Staffing has become a bigger problem more recently, not as many aides on as we used to. They [other residents] say they don't get their showers when scheduled and it can take an hour for staff to answer a call for help. All the residents are aware of the shortage of staff. They told me that people get sick and call out, they have been having open house to hire but people don't show up we have	F 353	monthly and is responsive to concerns when raised. B. Current residents have the potential to be affected. C. The Scheduling Manager will staff the facility at or above the minimum staffing requirements. The Nursing Leadership will meet individually with each member of the Resident Council to determine specifics about sufficient nursing staff and assess staffing needs based upon feedback from residents. D. The Recreation Director/designee will complete audits (Attachment 9) on 10% of the resident population daily until 100% compliance is achieved on 3 consecutive reviews. then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be presented to the monthly QAPI committee meetings for review & recommendations.	

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been losing the regular ones because they have been exhausted and burned out from working short. May have one aide for 28 residents on 3-11 and 11-7. They take one aide and split 1/2 shift on East unit and half on Central unit. It happened last night. Staff doing doubles. I've been here 5 years."

During stage I interviews the following residents answered "no" when asked "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" and each further explained;

7/5/17 at 3:01 PM - A1 "definitely not, only one (CNA) at all times, in our section."

7/5/17 at 3:34 PM - A2 "they don't always come and I guess it's because of staff shortage and I know when I have to go to the bathroom and that's what complaint I have with them. They clean you up, but I like to go to the bathroom and they take too long."

7/5/17 at 3:49 PM - A3 answered "the wait is more than half an hour."

7/6/17 at 8:25 AM - A4 "callouts and they don't show up, are understaffed".

7/6/17 at 11:34 AM - A5 staff is "short at night".

7/6/17 at 2:46 PM - A6 "not enough staff, short on aides."

7/6/17 at 2:55 PM - A7 "I have noticed they are short. When I came in May and the first part of June there would be 4 CNA's. When I had to have 2 CNA's to turn me they would have to wait

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F 353	Continued From page 33 and that happened quite often. Recently I can feel when I pee and they would wait so long they would have to change the bed. With not as many people on the floor they end up having to change the sheets and everything else because I've peed 2-3 times before they come. It happens about once a day, usually at nighttime the nightshift changes me around 11:00 PM and then its not until about 6:30 AM that they get to me again and they have to change the sheets." 7/7/17 at 10:22: AM - A8 "Not even close. The longest I had to wait is one hour and I was having pain." 7/7/17 at 10:56 AM - A9 " I can never find an aide daytime and on the weekends callouts and they still need another aide." 7/7/17 at 11:10 AM - A10 "Sometimes they are slow and I have had to wait twenty minutes." These findings were reviewed on 7/13/17 at 2:15 PM during exit conference with E1 (NHA) and E2 (DON).	F 353		
F 406 SS=D	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-	F 406		8/26/17

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F 406	Continued From page 34 (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R129) out of 45 sampled residents the facility failed to coordinate the provision of Level 2 PASARR specialized services for mental illness. Findings include: The following was reviewed in R129's clinical record: 11/13/16 - Admission to the facility from the community with diagnoses which included schizophrenia and depression. 5/23/17 - PASARR level 2 determination indicates the Individual requires specialized services and needs can be met in a nursing facility (NF). Please provide recommendations below. The individuals' needs can be met in a Nursing Facility with additional specialized services. Specialized Services: R129 is to be afforded the regular and ongoing services of a psychiatrist to handle her mental health and medication management. These services are to be provided on at least a quarterly basis. Additionally she is to be offered supportive counseling which is to be provided by a licensed mental health provider. The facility was fax'd this document on 5/30/17	F 406	A. R129 is scheduled for Psychiatrist appointment on August 23, 2017. The facility will facilitate appointments per Psychiatrist recommendations. B. Current residents were reviewed and no other Level 2 residents require specialized services at this time. C. The CED/designee will educate admissions that all Level 2 PASRRs must be reviewed by the CED or CNE to determine that recommended services are available prior to accepting the admission. D. The Social Service Director/designee will complete audits (Attachment 10) for PASRRs with Level 2 recommendations for services to verify specialized services are in place until 100% compliance is achieved for 6 consecutive months. Results will be presented to the monthly QAPI committee meeting for review and recommendations.	

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F 406	Continued From page 35 7/11/17 around 2:40 PM - Interview with E13 (SW) revealed s/he was unaware of Level 2 specialized services for this resident and revealed that the facility does not have a psychiatrist on contract and the mental health provider group providing counseling does not have a psychiatrist to see residents. A follow-up interview revealed that the facility would be seeking the services of a psychiatrist to meet R129's needs. These findings were reviewed with E1 (NHA) and E2 (DON) on 7/13/17 at 2:15 PM.	F 406		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 428		8/26/17

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F 428	Continued From page 36 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined for one (R191) out of 45 sampled residents it was determined that the monthly pharmacy review failed to identify the lack of AIMS assessment for the use of anti-psychotic medication. Findings include: The following was reviewed in R191's clinical record: 1/6/17 - Seroquel 25 mg bid for psychotic behaviors.	F 428	A. AIMs was completed for R191 on 7/12/17. B. Current residents on psychotropic medications were reviewed on 8/2/17 and AIMs testing are in place per policy. C. The CED spoke with Consultant Pharmacist on 8/2/17 regarding the need for AIMs testing to be reviewed for any resident requiring and including this on monthly pharmacy consultant reviews.	

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F 428	Continued From page 37 2/1/17, 3/2/17, 4/4/17, 5/1/17, and 6/1/17 - Pharmacy reviews with no mention of AIMS. 6/28/17 - Abilify 5 mg qd for psychosis. 7/3/17 - Pharmacy review with no mention of AIMS. 7/12/17 11:03 AM - Interview with E18 (LPN) revealed no AIMS could be found in the clinical record. These findings were reviewed with E1 (NHA) and E2 (DON) on 7/13/17 at 2:15 PM.	F 428	The Consultant Pharmacist will use the OSCAR system alerts for AIMs completion needed and will include this on his monthly review documentation. D. The CNE/designee will complete monthly audits on all Consultant Pharmacist Reviews for accuracy of AIMs recommendations until 100% compliance is achieved for 6 consecutive months. Results of audits will be reported to the monthly QAPI committee meeting for review and recommendations.	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		8/26/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 39 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to maintain an effective infection prevention and control program by failing to ensure: 1. House-wide infection/communicable disease surveillance with data analysis completed in April, 2017. 2. Tuberculosis (TB) testing was completed for one (E16) out of 16 sampled recently-hired employees. 3. 2-step TB skin testing was completed for one (R150) out of 6 sampled residents. 4. Germicidal wipes used for cleaning medical equipment (i.e., glucometer) were not expired. Findings include: 1. Surveillance January 2017 - July, 2017 - Review of the facility infection and communicable disease data discovered no information was compiled for the month of April, 2017. During an interview with E2 (DON) on 7/13/17 around 8:30 AM it was confirmed the facility was "in between" infection prevention staff and data was not collected in the month of April, 2017. 2. Employee TB Testing Facility policy entitled Tuberculosis Screening (last revised 7/18/16) included that TB screening	F 441	A. #1- Current process is in place for completing house-wide infection/communicable disease surveillance with data analysis. #2- E16 received 2 step TB testing and documentation of results were completed 7/28/17. #3- R150 no longer resides in facility. #4- All areas were checked for expired supplies and were removed on 7/12/17. B. Current residents have the potential to be affected. C. The NPE was re-educated on the house-wide infection/communicable disease surveillance with data analysis process, and the employee and resident TB testing policy & procedures and tracking requirements. The NPE is monitoring the EMR dashboard for resident TB testing completion documentation. The NPE completed the 2 step TB testing documentation education with licensed nursing staff in June 2017. The NPE will complete education with licensed nursing staff regarding checking medication carts and medication rooms for expired medications/supplies. D. Results of the monthly infection/communicable disease	

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F 441	Continued From page 40 will be provided for all existing and potential employees. Contractors who provide routine services (e.g. beauticians, etc.) must follow the same guidelines for TB screening as employees. Review of information human resources recorded on a personnel audit spreadsheet provided by the surveyor, there was no evidence that TB testing was performed for E16 (Housekeeper) hired 9/24/16 through a contract service. During an interview with E17 (Human Resources) on 7/13/17 at 9:10 AM, when asked if the TB testing could be obtained from the outside agency, the response was "No." During an interview with E1 (NHA) on 7/13/17 at 11:13 AM E1 confirmed that the contract agency did not have any TB testing results nor did the facility complete testing upon hire over 9 months ago. 3. Resident TB Testing Facility policy entitled Tuberculosis Management (last revised 11/28/16) documented all patients will be screened for tuberculosis on admission to the center according to CDC recommendations. CDC guidelines for Tuberculin Skin Testing (TST), last revised 5/11/16, documented the ability to react to the skin test diminishes years after infection creating a false-negative reaction [person has TB infection but skin test does not show it]. The skin test may stimulate the immune system causing a positive reaction on subsequent tests. Giving a second test after the initial one is called two-step testing. Two-step testing is useful for the initial testing of adults who would be tested	F 441	surveillance will be presented in the monthly QAPI committee meeting for review & recommendations. The NPE/designee will complete employee and resident TB testing audits (Attachment 11) weekly until 100% compliance is achieved on 6 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. The Nurse Unit Managers/designee will complete medication cart & medication room audits (Attachment 12) weekly until 100% compliance is achieved on 6 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be presented to the monthly QAPI committee meeting for review & recommendations.	

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F 441	Continued From page 41 periodically, to reduce the chance of a boosted reaction. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm Review of R150's closed clinical record revealed: 4/26/17- Admitted to the facility. April/May 2017 - R150's MAR and progress notes documented the Step 1 of PPD (TB skin testing) was scheduled to be given on 4/26/17 and administered on 4/27/17. There was no evidence that the skin test was read nor that the second skin test was administered. 7/11/17 around 9:40 am - an interview with E2 (DON) revealed for R150 that step 1 was administered and not read and that step 2 was never initiated. 4. Germicidal Wipes Surveyor observations and interviews: 7/11/17 at 2:58 PM, the surveyor observed that there were two boxes of germicidal bleach wipes in the medication room on Central Unit. One box had approximately 40 out of 100 wipes left with an expiration date of January 2017 and another full box had a February 2017 expiration date. At approximately 3:10 PM the same day, the surveyor informed E1 (NHA) that there were expired germicidal wipes in medication room. E1 immediately removed and replaced the wipes. 7/12/17 at 9:30 AM, the surveyor checked the medication cart on Homestead Unit and asked E7 (LPN) what does he/she use to clean glucometers. E2 went to get a container disinfectant (bactericidal) towels (wipes) for the	F 441		

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F 441	Continued From page 42 cart and stated that the towels (wipes) were used to clean the glucometers. The expiration on the container was February 2017. E7 removed the wipes from the cart. These findings were reviewed E1 and E2 [DON] at the exit conference on 7/13/17 at approximately 2:15 PM.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

FACILITY: Milford Center

DATE SURVEY COMPLETED: July 13, 2017

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from July 5, 2017 through July 13, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 124. The survey sample totaled forty-five (45).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on July 13, 2017. F241, F253, F272, F276, F280, F285 F309, F325, F329F, F353, F406, F428, F441.	Cross Refer to the CMS 2567-L survey completed on July 13, 2017. F241, F253, F272, F276, F280, F285, F309, F325, F329, F406, F428, F441.	8/26/17

Provider's Signature Bruce Lemin Title Administrator Date 8-4-17